Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
WOL+MED
EDWARD WOLSKI MD
2436 I-35 EAST SOUTH STE 336
DENTON TX 76205

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Date Received
JUNE 18, 2004

MFDR Tracking Number
M4-04-A669-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "PEC-H and No response. The carrier denied full reimbursement stating they were paying only 50% of the charges up front. However, we have yet to see any of the other part of the payment. We have waited for further information from the carrier concerning any audit being performed, but they have failed to notify us why other parts of the treatment are being denied… We feel there is no justification for withholding the remaining payment amount. We are entitled to reimbursement according to 133.1(8)… Additionally, the carrier failed to respond to our request for reconsideration. They have violated Rule 133.304(l)…"

Amount in Dispute: $10,770.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carrier's contention that Wol Med, Edward Wolski MD did not properly request for reconsideration in accordance with Chapter 133.304(k)… They have provided nothing to show they have complied with RULE 133.304(k) or (l). Thus, it is Carrier's position that Wal Med, Edward Wolski, MD has failed to submit a PROPER request for reconsideration and thus request the Medical Dispute Resolution Request be dismissed.

Response Submitted by: Hartford Casualty Insurance Co., PO Box 4996, Syracuse, NY 13221

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 8, 2003 December 9, 2003 December 10, 2003 December 11, 2003 December 12, 2003 December 15, 2003 December 16, 2003 December 17, 2003 December 18, 2003	CPT Codes 97545-WH-CA & 97546-WH-CA	$7,010.00	$6,944.00

December 19, 2003 December 22, 2003 December 23, 2003 December 24, 2003 December 26, 2003 January 5, 2004 January 6, 2004 January 7, 2004			
January 13, 2004 January 15, 2004 January 21, 2004 January 26, 2004 January 27, 2004 January 28, 2004 January 29, 2004	CPT Codes 97545-WH-CA & 97546-WH-CA	$3,136.00	$0.00
January 30, 2004	CPT Codes 97545-WH-CA & 97546-WH-CA	$320.00	$0.00
February 2, 2004	CPT Code 97750-FC	$411.60	$0.00
February 4, 2004	CPT Codes 99214, 72100-WP & 72070-WP	$182.80	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. The requestor submitted an updated table dated June 19, 2004 withdrawing September 19, 2003, September 20, 2003, September 22, 2003, September 24, 2003, October 8, 2003, October 10, 2003, October 13, 2003, October 15, 2003, October 21, 2003, October 29, 2003, November 10, 2003, November 11, 2003, November 14, 2003, November 15, 2003, November 21, 2003, November 22, 2003, December 4, 2003, January 2, 2004, and February 6, 2004.

   The respondent submitted payment screens supporting payment, with check number 38759042, had been made for CPT Code 97750-FC in the amount of $428.40 for date of service February 2, 2004; and check number 28276104, had been made for CPT Codes 99214, 72100-WP and 72070-WP in the amount of $424.13. Therefore the Division had deemed these services are no longer in dispute and will not be reviewed.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §134.202 sets out the reimbursement guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 2, 2004, February 11, 2004, February 13, 2004, February 20, 2004, February 3, 2004, February 25, 2004, February 26, 2004, February 27, 2004, March 10, 2004, March 11, 2004, March 17, 2004
   - H – Reimbursement is based upon half of the fee amount pending decision of audit or review.
   - 150 – Pymt adj because the payer deems the info on submitted doesn't support this lvl of service. A peer review obtained by the carrier indicates that documented services don't meet minimum fee guideline and/or rules of coding.
   - N – A peer review obtained by the carrier indicates that the documented services do not meet minimum fee guideline and/or the rules contained within the applicable AMA CPT/HCPCS coding guidelines.
   - W9 – Unnecessary med treatment based on peer review. Payment withheld as peer review indicates documentation does not support the treatment to be medically reasonable and/or necessary.

Issues

1. Did the requestor submit documentation to support request for reconsideration was made to the insurance carrier in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor submit documentation to support services were rendered as billed?
3. Did the requestor submit services denied with medical necessity issue?

4. Is the requestor entitled to reimbursement?

Findings

1. The requestor submitted the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307.
2. The respondent denied the services in dispute using denial/reason codes H – 'Reimbursement is based upon half of the fee amount pending decision of audit or review"; 150 – "Pymt adj because the payer deems the info on submitted doesn't support this lvl of service"; and "N – A peer review obtained by the carrier indicates that the documented services do not meet minimum fee guideline and/or the rules contained within the applicable AMA CPT/HCPCS coding guidelines." The respondent paid half of the fee amount pending a decision of an audit or review. The respondent did not submit any documentation to support their position that they performed an audit or review for the disputed services. The Division therefore concludes that this denial reason is not supported. The services will therefore be reviewed per applicable statutes and Division rules. The respondent also denied the services using denial code 150 - Pymt adj because the payer deems the info on submitted doesn't support this lvl of service. A peer review obtained by the carrier indicates that documented services don't meet minimum fee guideline and/or rules of coding" and N – "A peer review obtained by the carrier indicates that the documented services do not meet minimum fee guideline and/or the rules contained within the applicable AMA CPT/HCPCS coding guidelines." The respondent did not submit any documentation to support their position that the disputed service did not support the level of service provided or that the documented service do not meet minimum fee guideline and/or the rules contained within the applicable AMA CPT/HCPCS coding guidelines.. The Division therefore concludes that this denial reason is not supported. The services will be reviewed per applicable statutes and Division rules. In accordance with 28 Texas Administrative Code §133.307(g)(3)(B) the requestor submitted pertinent medical records to support the services were rendered as billed for dates of service December 8, 2003 through January 7, 2004. Therefore additional reimbursement for these dates of service is recommended.

   The requestor did not submit medical records for dates of service January 13, 2004 through January 29, 2004; therefore reimbursement is not recommended for these dates of service.
3. The insurance carrier denied date of service January 30, 2004 using denial/reason code W9 – "Unnecessary med treatment based on peer review. Payment withheld as peer review indicates documentation does not support he treatment to be medically reasonable and/or necessary." In accordance with 28 Texas Administrative Code §133.308(a)(1) dates of service filed or after January 1, 2003 medical fee disputes with services denied for unnecessary medical treatment are to be resolved by an Independent Review Organization. Therefore, this date of service was not reviewed by Medical Fee Dispute Resolution.
4. Review of the submitted documentation finds that additional reimbursement is due for dates of service December 8, 2003 through January 7, 2004 in accordance with 28 Texas Administrative Code §134.202(e)(5)(C)(i-ii).

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $6,944.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $6,944.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 11, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.